Indiana State Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBI		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURV COMPLETED		
				A. BUILDING	<u> </u>	R		
	012684			B. WING		10/11/2012		
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA				
VITAS HE	ALTHCARE CORPORAT	ION MIDWEST		ITH VALLEY F OD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
{S 000}) INITIAL COMMENTS			{S 000}				
	This visit was for a follow-up to the Initial Hospice COP certification survey conducted on February 8-10, 2012, that resulted in conditions being cited.							
	Survey date: Octobe	er 10 and 11, 2012						
	Facility #: 012684							
	Medicaid Vendor #:	N/A						
	Surveyors: Marty Coons, RN, PHNS, Team Leader							
	·	is, RN, BSN, PHNS						
	As a result of this survey, 2 COP and 12 standard level deficiencies were found corrected. Vitas Healthcare Corporation Midwest was found to be back in compliance with IC 16-25-3 and the Condition of Participation 42 CFR 418.56 Interdisciplinary Group, Care Planning, and Coordination of Services and 418.76 Hospice aide and homemaker services.		as to be					
	Active Census-6 Record Review-4							
		e Elder, MSN, BSN, RN r 15, 2012	I					
{S 512}	418.52(c)(1) RIGHTS	OF THE PATIENT		{S 512}				
		pain management and the hospice for conditi	ons					
	This STANDARD is	not met as evidenced b	y:					

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		012684		A. BUILDING B. WING		10	R)/11/2012	
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE	E, ZIP CODE	•		
VITAS HE	ALTHCARE CORPORA	ATION MIDWEST	l .	IITH VALLEY RE OOD, IN 46142) STE 214			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY F IR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
{S 512}	Continued From pa	ge 1		{S 512}				
{S 522}	522} 418.54(a) INITIAL ASSESSMENT The hospice registered nurse must complete initial assessment within 48 hours after the election of hospice care in accordance with §418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.			{S 522}				
			nitial					
	This STANDARD is	s not met as evidenced b	py:					
{S 523}	418.54(b) TIMEFRA	AME FOR COMPLETION	N OF	{S 523}				
	The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice of accordance with §418.24.		care in					
	This STANDARD is	s not met as evidenced b	py:					
{S 530}	418.54(c)(6) CONT ASSESSMENT	ENT OF COMPREHENS	SIVE	{S 530}				
	consideration the form (6) Drug profile. A prescription and overemedies and other	re assessment must take ollowing factors:] review of all of the patier er-the-counter drugs, he ralternative treatments the erapy. This includes, but	nt's rbal nat					

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STATE FORM 2KGH12 If continuation sheet 2 of 16

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	012684			B. WING		R 10/11/2012	
NAME OF PR	OVIDER OR SUPPLIER	0.2001	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	10/1	
VITAS HE	VITAS HEALTHCADE CODDODATION MIDWEST			ITH VALLEY F OD, IN 46142			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
{S 530}	Continued From page	e 2		{S 530}			
	not limited to, identification of the following:						
	(i) Effectiveness of dr (ii) Drug side effects (iii) Actual or potentia (iv) Duplicate drug the (v) Drug therapy curre laboratory monitoring	Il drug interactions erapy ently associated with					
	This STANDARD is not met as evidenced by:		y:				
{S 533}	418.54(d) UPDATE C ASSESSMENT	DF COMPREHENSIVE		{S 533}			
	The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.		the must ce the on on nes, must ion of				
	This STANDARD is I	not met as evidenced b	y:				
{S 534}	418.54(e)(1) PATIEN	T OUTCOME MEASUF	RES	{S 534}			
		ve assessment must inc low for measurement o					

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		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	OT PROVIDER OR SUPPLIER			A. BUILDING		R		
				B. WING		10	0/11/2012	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE			
VITAS HE	ALTHCARE CORPOR	ATION MIDWEST		IITH VALLEY RI OD, IN 46142	D STE 214			
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{S 534}	534} Continued From page 3			{S 534}				
	document data in the data elements aspects of care rel	ospice must measure and the same way for all paties must take into consideral lated to hospice and pallial is not met as evidenced by	ation ation.					
{S 535}	[S 535] 418.54(e)(2) PATIENT OUTCOME MEASURI			{S 535}				
	the comprehensive documented in a s for each patient. T patient must be us planning and in the must be used in the	ents must be an integral per assessment and must be assessment and must be experiently as a second in	e way th ire , and					
	This STANDARD	is not met as evidenced b	py:					
{S 559}	418.58 QUALITY A			{S 559}				
	This CONDITION	is not met as evidenced l	by:					
{S 560}	418.58 QUALITY A			{S 560}				
	The hospice must	develop, implement, and						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM				MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	<u>'</u>	
VITAS HE				ITH VALLEY F OD, IN 46142			
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{S 560}	Continued From page 4			{S 560}			
	maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.						
	This STANDARD is I	not met as evidenced b	y:				
{S 561}	418.58(a)(1) PROGR	AM SCOPE		{S 561}			
	(1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.						
	This STANDARD is i	not met as evidenced b	y:				
{S 562}	418.58(a)(2) PROGR	AM SCOPE		{S 562}			
	 418.58(a)(2) PROGRAM SCOPE (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations. 						

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		(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		012684		B. WING	 -	10/	R / 11/2012		
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>	STREET ADD	RESS, CITY, STAT	E, ZIP CODE	10/	11/2012		
VITAS HE	ALTHCARE CORPORAT	TION MIDWEST	1	N SMITH VALLEY RD STE 214 NWOOD, IN 46142					
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{S 562}	Continued From pag	e 5		{S 562}					
	This STANDARD is not met as evidenced								
{S 563}	 {S 563} 418.58(b)(1) PROGRAM DATA (1) The program must use quality indicator d including patient care, and other relevant dat the design of its program. This STANDARD is not met as evidenced by 			{S 563}					
			y:						
{S 564}	418.58(b)(2) PROG	RAM DATA		{S 564}					
	(2) The hospice must use the data collected the following:(i) Monitor the effectiveness and safety of services and quality of care.(ii) Identify opportunities and priorities for improvement.		to do						
	This STANDARD is	NDARD is not met as evidenced by:							
{S 566}	418.58(c)(1)(i) PRO	GRAM ACTIVITIES		{S 566}					
	(1) The hospice's performance improvement activities must:(i) Focus on high risk, high volume, or problem-prone areas.		t						
	This STANDARD is	not met as evidenced b	oy:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
	012684			B. WING			₹ 4/2042		
NAME OF PR	OVIDER OR SUPPLIER	012664	STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	10/1	1/2012		
				V SMITH VALLEY RD STE 214 NWOOD, IN 46142					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE		
{S 566}	Continued From page 6			{S 566}					
{S 567}	418.58(c)(1)(ii) PROGRAM ACTIVITIES [The hospice's performance improvement activities must:] (ii) Consider incidence, prevalence, and severity of problems in those areas.		rerity	{S 567}					
	This STANDARD is not met as evidenced by:		y:						
{S 568}	418.58(c)(1)(iii) PRO	GRAM ACTIVITIES		{S 568}					
	[The hospice's performance improvement activities must:] (iii) Affect palliative outcomes, patient safety, quality of care.		v, and						
	This STANDARD is r	not met as evidenced by	y:						
{S 569}	418.58(c)(2) PROGR	AM ACTIVITIES		{S 569}					
	(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.		nd						
	This STANDARD is r	not met as evidenced by	y:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED R				
		012684		B. WING		10/11/2012			
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE				
VITAS HE	ALTHCARE CORPORAT	TION MIDWEST		N SMITH VALLEY RD STE 214 NWOOD, IN 46142					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU ELSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
{S 570}	Continued From page 7			{S 570}					
{S 570}	 418.58(c)(3) PROGRAM ACTIVITIES (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: 			{S 570}					
			y:						
{S 571}	418.58(d) PERFORI PROJECTS	MANCE IMPROVEMEN	Т	{S 571}					
	Beginning February 2, 2009, hospices must develop, implement and evaluate performance improvement projects.								
	This STANDARD is	not met as evidenced b	y:						
{S 573}	418.58(d)(2) PERFO PROJECTS	DRMANCE IMPROVEM	ENT	{S 573}					
	conducted, the reason	t document what ement projects are being ons for conducting these easurable progress achie	;						
	This STANDARD is	not met as evidenced b	y:						
{S 574}	418.58(e)(1) EXECU	JTIVE RESPONSIBILIT	ES	{S 574}					
	The hospice's gover	ning body is responsible	for						

Indiana State Department of Health STATE FORM

Indiana State Department of Health

		(X1) PROVIDER/SUPPLIER/O			PLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
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NAME OF PR	OF PROVIDER OR SUPPLIER STREE			RESS, CITY, STA	TE, ZIP CODE			
VITAS HE	ALTHCARE CORPORATI	ION MIDWEST		IITH VALLEY I OD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
{S 574}				{S 574}				
	ensuring the following: (1)That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.							
	This STANDARD is not met as evidenced by:		y:					
{S 575}	418.58(e)(2) EXECU	TIVE RESPONSIBILITI	ES	{S 575}				
	[The hospice's governing body is responsible for ensuring the following:] (2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.		nt and					
	This STANDARD is r	not met as evidenced by	y:					
{S 576}	418.58(e)(3) EXECU	TIVE RESPONSIBILITI	ES	{S 576}				
	[The hospice's governing body is responsible for ensuring the following:] (3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.							

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		(X1) PROVIDER/SUPPLIER/O		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	IDENTIFICATION NO			A. BUILDING B. WING		R			
		012684				10/11/2012			
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA					
VITAS HE	ALTHCARE CORPORAT	ION MIDWEST		9 W SMITH VALLEY RD STE 214 EENWOOD, IN 46142					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE		
{S 576}	Continued From page	e 9		{S 576}					
	This STANDARD is not met as evidenced by		y:						
{S 578}	The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases. This STANDARD is not met as evidenced by:			{S 578}					
			cts						
			y:						
{S 579}	418.60(a) PREVENT	ION		{S 579}					
	practice to prevent th	low accepted standards e transmission of infect iseases, including the u 	ions						
	This STANDARD is	not met as evidenced b	y:						
{S 596}	418.64(d)(1) COUNS	SELING SERVICES		{S 596}					
	limited to, the followir (1) Bereavement cou (i) Have an organized of bereavement servi supervision of a quali experience or educat counseling. (ii) Make bereavement	inseling. The hospice not program for the provisities furnished under the ified professional with	nust: ion e						

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
	012684		B. WING			R 10/11/2012			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
	ALTHCARE CORPORATI	ON MIDWEST	3209 W SMITH VALLEY RD STE 214 GREENWOOD, IN 46142						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
{S 596}	the patient. Bereaven extends to residents of when appropriate and bereavement plan of (iii) Ensure that bereaveneds of the bereave (iv) Develop a bereavenotes the kind of bereavenetes and the frequenetes.	ear following the death nent counseling also of a SNF/NF or ICF/MR didentified in the care. Inversely the care that the care th	t the	{S 596}					
	This STANDARD is r	not met as evidenced b	y:						
{S 704}	418.108 SHORT-TEF	RM INPATIENT CARE		{S 704}					
	This CONDITION is	not met as evidenced b	y:						
{S 705}	418.108 SHORT-TEF	RM INPATIENT CARE		{S 705}					
	symptom manageme and must be provided or Medicaid facility.	e available for pain con nt, and respite purpose I in a participating Medi	s, care						
	This STANDARD is r	not met as evidenced b	y:						
{S 707}	418.108(a)(2) INPATI SYMPTOM CONTRO			{S 707}					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
VITAS HE	ALTHCARE CORPORA	TION MIDWEST		TH VALLEY F OD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FU R LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
{S 707}	{S 707} Continued From page 11			{S 707}				
, ,	[Inpatient care for pain control and symptom management must be provided in one of the following:] (2) A Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in §418.110(b) and (e) regarding 24-hour nursing services and patient areas. This STANDARD is not met as evidenced by:			. ,				
			y:					
{S 710}	418.108(b)(2) INPA PURPOSES	TIENT CARE FOR RESI	PITE	{S 710}				
	The facility providing respite care must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.		ng es as					
	This STANDARD is	s not met as evidenced b	y:					
{\$ 711} 418.108(c)(1) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS			{S 711}					
	to provide for short- arrangement is desi coordinated by the l specifies-	n arrangement with a facterm inpatient care, the cribed in a written agreer hospice and at a minimule supplies the inpatient	ment,					

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		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
012684				B. WING		10/11/2012	
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VITAS HEALTHCARE CORPORATION MIDWEST			3209 W SMIT GREENWOOI				
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{S 711}	Continued From page	e 12	{	S 711}			
	provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;						
	This STANDARD is not met as evidenced by:						
{S 712}	418.108(c)(2) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS) {	S 712}			
	[If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (2) That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients;						
	This STANDARD is r	not met as evidenced by	y:				
{S 713}	418.108(c)(3) INPATII UNDER ARRANGEM	ENT CARE PROVIDED) {	S 713}			
	to provide for short-te arrangement is descri coordinated by the ho specifies-] (3) That the hospice p	ibed in a written agreen spice and at a minimur patient's inpatient clinica ord of all inpatient servi	nent, m				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
012684				B. WING		R 10/11/2012			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	10/11/2012			
VITAS HEALTHCARE CORPORATION MIDWEST				3209 W SMITH VALLEY RD STE 214 GREENWOOD, IN 46142					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE			
{S 713}	Continued From page	e 13		{S 713}					
	occurred at the facility; that a copy of the discharge summary be provided to the hospice at the time of discharge; and that a copy of the inpatient clinical record is available to the hospice at the time of discharge;								
	This STANDARD is r	not met as evidenced b	y:						
{S 714}	S 714} 418.108(c)(4) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS)	{S 714}					
	[If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (4) That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement;								
	This STANDARD is r	not met as evidenced b	y:						
{S 715}	418.108(c)(5) INPATI UNDER ARRANGEM	ENT CARE PROVIDED)	{S 715}					
	to provide for short-te arrangement is descri coordinated by the ho specifies-] (5) That the hospice r	arrangement with a farm inpatient care, the libed in a written agreer espice and at a minimulaterains responsibility for hing of personnel who were arrangement.	nent, n						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		012684	012684			R 10/11/2012			
			STREET ADD	RESS, CITY, STA	TE, ZIP CODE		11/2012		
VITAS HEALTHCADE CODDODATION MIDWEST				MITH VALLEY RD STE 214 OOD, IN 46142					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETE DATE			
{S 715}	Continued From pag	e 14		{S 715}					
	providing the patient's care in the inpatient facility has been provided and that a description of the training and the names of those giving the training is documented; This STANDARD is not met as evidenced by:								
{S 716}	{S 716} 418.108(c)(6) INPATIENT CARE PROVIDED UNDER ARRANGEMENTS		O	{S 716}					
	[If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-] (6) A method for verifying that the requirements in paragraphs(c)(1) through (c)(5) of this section are met.								
	This STANDARD is	not met as evidenced b	y:						
{S 782}	418.112(f) ORIENTA STAFF	TION AND TRAINING ()F	{S 782}					
	or ICF/MR staff furnis patients in the hospic hospice policies and methods of comfort, management, as wel and dying, individual	ssure orientation of SNI shing care to hospice ce philosophy, including procedures regarding pain control, symptom Il as principles about de responses to death, pa rms, and record keepin	ath tient						

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		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
012684			B. WING			R 10/11/2012		
			RESS, CITY, STA	TE, ZIP CODE	1			
VITAG LIFALTUGA DE CORRODATION MIDWEST			3209 W SMITH VALLEY RD STE 214 GREENWOOD, IN 46142					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (2)				
Continued From page 15			{S 782}					
This STANDARD is r	not met as evidenced by	y:						
	SOVIDER OR SUPPLIER ALTHCARE CORPORATI SUMMARY STA (EACH DEFICIENC' REGULATORY OR L	O12684 COVIDER OR SUPPLIER ALTHCARE CORPORATION MIDWEST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMATION COntinued From page 15	O12684 COVIDER OR SUPPLIER ALTHCARE CORPORATION MIDWEST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TOVIDER OR SUPPLIER ALTHCARE CORPORATION MIDWEST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 IDENTIFICATION NUMBER: A. BUILDING B. WING	A. BUILDING B. WING O12684 STREET ADDRESS, CITY, STATE, ZIP CODE 3209 W SMITH VALLEY RD STE 214 GREENWOOD, IN 46142 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 STREET ADDRESS, CITY, STATE, ZIP CODE 3209 W SMITH VALLEY RD STE 214 GREENWOOD, IN 46142 ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN STREET ADDRESS, CITY, STATE, ZIP CODE 3209 W SMITH VALLEY RD STE 214 GREENWOOD, IN 46142 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN Continued From page 15	A. BUILDING B. WING O12684 STREET ADDRESS, CITY, STATE, ZIP CODE 3209 W SMITH VALLEY RD STE 214 GREENWOOD, IN 46142 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLE A. BUILDING B. WING O12684 STREET ADDRESS, CITY, STATE, ZIP CODE 3209 W SMITH VALLEY RD STE 214 GREENWOOD, IN 46142 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 15 {S 782}		

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